

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-030997

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 391 Primary Registration District No. 4504 Registrar's No. 21

FILED JUL 23 1963

1. PLACE OF DEATH a. COUNTY <u>Stoddard</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Stoddard</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Advance</u>	Length of stay in 1b <u>40 years</u>	c. CITY OR TOWN <u>Advance</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>Strong</u> Last <u>Strong</u>			4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-97</u>	9. AGE (last birthday) <u>66</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>23</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	11. BIRTHPLACE (City and state or country) <u>Whitewater, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Elam Strong</u>		13b. MOTHER'S MAIDEN NAME <u>Belle Ward</u>		14. NAME OF HUSBAND OR WIFE <u>Gertrude Strong</u>	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>yes</u> <u>WWI</u>	16. SOCIAL SECURITY NO. <u></u>	17. INFORMANT <u>Gertrude Strong, Advance, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u>	INTERVAL BETWEEN ONSET AND DEATH <u>5 Min</u>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Circulatory Failure</u>	<u>5 Min</u>
	DUE TO (c) <u>Coronary Thrombosis</u>	<u>1 Hr.</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Bronchial Asthma</u>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from <u>July 8-88</u> to <u>7-8-63</u> and last saw her alive on <u>7-8-63</u>
Death occurred at <u>9:30 P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>L. A. Masters MD</u>	22b. ADDRESS <u>Advance Mo</u>	22c. DATE SIGNED <u>7-8-63</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>7-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Morgan Mem. Park</u>	23d. LOCATION (City, town, or county) <u>Advance, Mo.</u>	(State)
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24. FUNERAL DIRECTOR ADDRESS <u>Wm. H. Morgan, Advance, Mo.</u>	25. DATE RECD BY LOCAL REG. <u>7/11/63</u>	26. REGISTRAR'S SIGNATURE <u>Bernice Moore</u>
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(Licensed Embalmer's Statement on Reverse Side)

VS 300
Rev. 4/591 10302 1030

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

AUG 1 1963

AUG 19 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

W. H. Morgan

Licensed Embalmer No. 4640

P. O. Address Advance, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

-If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.